



WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN SERVICES, BUREAU FOR MEDICAL SERVICES

BMS MediWeb Portal
Administered by Health Information Designs, Inc.
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BMS MEDIWEB PORTAL DATABASE ACCESS REQUEST FORM

Please print or type, and use full name (first, middle initial, last, suffix (Jr., Sr., II, III, etc.))

Full Name: _____		
SSN: _____	DOB: _____	
Professional Title: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DDS <input type="checkbox"/> RPh <input type="checkbox"/> PharmD <input type="checkbox"/> DMD <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> OD <input type="checkbox"/> DPM		
State Board License Number/Expiration _____	DEA Number/Expiration _____	National Provider Identifier (NPI) _____
E-mail Address: _____		
Facility Name: _____		
<small>(Pharmacists - supply your pharmacy name; PAs - supply the name of your supervising physician; NPs - supply the name of your collaborative physician; emergency room physicians – supply your hospital name.) NPs & PAs: PWP/RXA# _____</small>		
Facility Address: _____		
City/County: _____	State/ZIP Code: _____	
Phone Number: _____	Fax Number: _____	
Proposed Password (must contain at least 8 characters, at least 1 capital letter, 1 lowercase letter, and 1 number.) _____		
Prescriber/Dispenser's Signature: _____		
Subscribed and worn to before me in the County of _____, State of _____		
this _____ day of _____, 20____.		
		_____ NOTARY PUBLIC
Notary Public Seal		My Commission expires: _____

By signing this agreement, I acknowledge that I am a licensed prescriber or pharmacist in the State of West Virginia or in the state in which I practice. I certify that all information is correct and I will abide by all State and Federal regulations pertaining to the privacy of a patient's medical information.

Mail the following items to the BMS MediWeb Portal Program to the address at the top of this form:

Notarized Database Access Request Form
Copies of WV Current Board License and DEA Registration